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Patient Information

Please take a few minutes to fill out this 3 page form as complete as you can. Sign and date authorization on page 3.

Name_____ Soc. Sec.#_____
Last Name *First Name* *Middle Initial*

Address_____

City_____ State_____ Zip_____ Home Ph#_____

Cell Ph#_____ E-mail_____

Sex ❑ M ❑ F Age_____ Birthdate_____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by_____ Occupation_____

Business Address_____

Business e-mail_____ Work Ph#_____

How did you hear about us? ❑ Family member ❑ Friend ❑ Associate Referral Name_____

Notify in case of emergency_____ Best Contact Ph#_____

Second Ph#_____ E-mail_____

We Strive to fulfill your individual dental needs. Please help us learn more about you by answering the two questions below. Thank you.

Are you having any concerns or dental discomfort?_____

_____

_____

What would you like us to do? _____

_____

_____

Insurance Information Continued On Page 2

Dental Insurance Information

As a courtesy to you, we will file and submit all insurance claims on your behalf.

Primary Insurance

Insurance Company_____ Phone:_____

Member ID Number_____ Group Number_____

Employer: (Name of employer through which you are insured)_____
*If plan has been purchased Individually, please state "Self"

Name of other dependents under this plan_____

Policy Holder Information: (This is the main person on the plan, ex. Spouse or Parent)

Name_____ Relationship to Patient_____
Last Name *First Name* *Middle Initial*

Date of Birth_____ Soc. Sec.#_____

City_____ State_____ Zip_____ Home Ph#_____

Cell Ph#_____ E-mail_____

Person Responsible Employed by_____ Occupation_____

Business Address_____

Business E-mail_____ Work Ph#_____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No If yes, please fill out form below:

Insurance Company_____ Phone:_____

Member ID Number_____ Group Number_____

Employer: (Name of employer through which you are insured)_____

Name of other dependents under this plan_____

Policy Holder Information: (This is the main person on the plan, ex. Spouse or Parent)

Name_____ Relationship to Patient_____

Date of Birth_____ Soc. Sec.#_____

City_____ State_____ Zip_____ Home Ph#_____

Cell Ph#_____E-mail_____

Dental & Medical History Continued On Page 3

Dental History

Former Dentist_____ Address_____

Dentist Email_____Phone_____

Date of last dental care_____ Date of last x-rays_____

Check (✓) yes if you have had problems with any of the following:

❑ Yes – Bad Breath
❑ Yes – Bleeding gums
❑ Yes – Clicking or popping jaw
❑ Yes – Food collection between teeth
❑ Yes – Grinding/Clenching teeth
❑ Yes – Loose teeth/broken fillings
❑ Yes – Periodontal treatment
❑ Yes – Sensitivity to cold
❑ Yes – Sensitivity to hot
❑ Yes – Sensitivity to sweets
❑ Yes – Sensitivity when biting
❑ Yes – Sores or lumps in mouth

How often do you brush?_____ Floss?_____

How do you feel about the appearance of your teeth?_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ No ❑ Yes

Other information about your dental health or previous treatment_____

Medical History

Physician's name_____Phone_____Date of last visit_____

Have you had any serious illnesses or operations? ❑ No ❑ Yes Head/Neck/Back injury? ❑ No ❑ Yes

If yes, describe_____

Are you currently under a physicians care? ❑ No ❑ Yes If yes, describe_____

Have you ever had blood transfusion? ❑ No ❑ Yes If yes, give approximate dates_____

Have you ever taken Fen-Phen/Redux? ❑ No ❑ Yes

Women: Are you pregnant? ❑ No ❑ Yes Nursing ❑ No ❑ Yes Taking birth control pills? ❑ No ❑ Yes

Check (✓) yes or no whether you have had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial Heart Valve
❑ Y ❑ N Artificial Joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (Allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical Dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe:
❑ Y ❑ N Heliophilia/bleeding
❑ Y ❑ N Herpes
❑ Y ❑ N Hepatitis
❑ Y ❑ N High Blood pressure
❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wood, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/Heart Surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Hepatitis
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal Disease

Is the patient currently taking any medications? If yes list all:

_____

Does the patient have drug allergies? If yes list all:_____

Authorization – please sign and date

– I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in medical status, I will inform the dentist.
– I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
– I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____Date_____

Payment is due in full at the time of treatment, unless prior arrangements have been approved. – Thank you